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No. 270.—Vol. XXIII, No. 4.] [APRIL, 1911.

THE BRITISH JOURNAL OF DERMATOLOGY

THE PROPERTY OF 18 QUEEN

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APRIL, 1911.

A CASE OF WIDESPREAD BULLOUS AND HÆMORRHAGIC ERUPTION, WITH GRAVE CONSTITUTIONAL SYMPTOMS; RECOVERY.

By E. G. FEARNSIDES, M.A., M.B., B.C.Cantab., B.Sc.Lond., M.R.C.P.,
Medical Registrar to the London Hospital.

The following case of skin-eruption is chiefly of interest because of the multiformity of the lesions and the severity of the "typhoid state" associated with them. Clinically the case appeared to be a streptococcic septicæmia, with the scalp as a source of infection, but the blood cultures taken remained sterile and failed to prove the diagnosis.

M. R—, a waitress, aged 20 years, was admitted to the London Hospital, under the care of Dr. Cecil Wall, on January 7th, 1911.

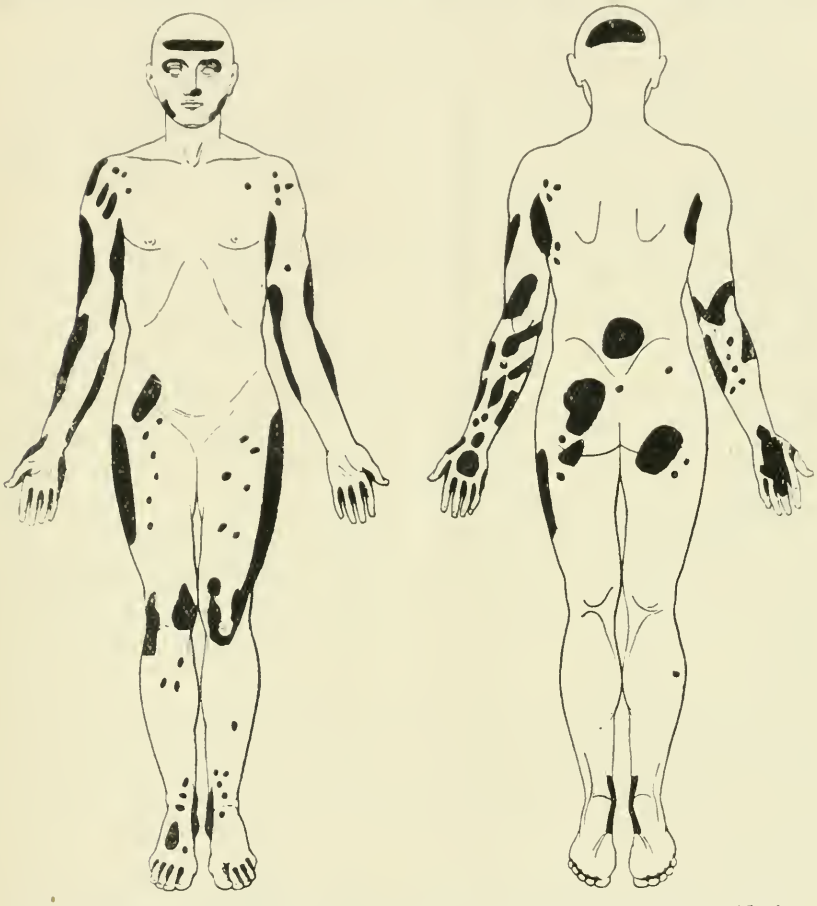
History.—On admission she stated that she had been in her usual good health till some days before Christmas, 1910. On December 20th she stopped work, complaining of "aches in her limbs" of a severity not sufficient to keep her from going about, but sufficient to prevent her from following her employment as a waitress in a restaurant. On December 24th she first complained of acute pains; the pains were of a gnawing character, and localised to the region of her right lower thigh and knee. On the following day the right knee continued to be very painful, and she noticed that it was swollen. On the 26th her right ankle also became painful, and was seen to be much swollen. She kept about all this day, but in the evening "an acute attack of vomiting" started, and "she could keep nothing

down." She went to bed. During the night she vomited several times. She felt very sick, but had no abdominal pain. As soon as she got to bed her friends noticed that she had a "blood-red rash" on her left hand, and on search similar places were found on the back of her left elbow. On the 27th she vomited several times: blebs appeared over and around the red spots noticed on the previous evening, and a further crop of spots and blebs appeared over the back of her right hand, and at a somewhat later date on her right elbow, the front of both knees, and also on the top and inner side of both feet. During the next day or so the blebs seemed to run together and form "blood blisters." She felt very ill in herself, and since the night of the 26th has been continuously in bed at home. On the 28th the rash appeared on her forehead, right ear, and nose; she became mentally dull, "queer altogether," and at night-time "light-headed." A succession of "red places," "dark spots," and "blood-blisters" have since this date appeared and faded; a little itching precedes the appearance of the red places. With each successive crop she has become more and more ill. She has had no rash or spots on her trunk.

Previous history.—Her previous health had been uniformly good. As a child she had had measles and children's complaints, but since girlhood she has had no illness of any description. She is the third of four children, born and brought up in the country. Her father and mother are still alive and healthy. She is unmarried, and lives in Plaistow with a married sister. She knows of no cause for the onset of her present illness. There are no cases of fever or other infectious illness in the near vicinity.

On admission she was seen to be acutely ill, lethargic and drowsy, sleeping with half-closed eyes, and gave an appearance suggestive of a woman of upwards of forty-five years of age. She answered questions with regard to herself and her illness lucidly and correctly, but there was always a long pause between question and reply. Her speech was thick and her articulation poor. Her face showed a malar flush, was generally pallid and completely expressionless. Her eyes were sunken, and showed muco-purulent conjunctivitis. Her lips were dry, cracked, and covered with sordes. Her skin generally was moist and clammy. Her mucous membranes were not markedly anæmic. Her tongue was dry, cracked, shiny, and denuded of all fur.

Her gums were dry, retracted away from her teeth, and covered with blood-stained dried deposit. Her hair was matted with nits, active pediculi, and scabs, and was extremely dirty. She showed no enlargement of lymphatic glands. On admission her temperature was



Diagrams illustrating the distribution of the eruption in Dr. Fearnsides' case. Note (1) the general involvement of the extensor aspects and freedom of the flexor surfaces of the limbs, especially on the hands and feet; (2) the comparative freedom of the trunk.

99·4 F., her pulse-rate 118, irregular in rhythm, feeble, running, and of low tension; her respiratory rate was 20.

The eruption.—There was a more or less symmetrical eruption of widespread distribution chiefly involving the limbs, the upper to a greater extent than the lower, the extensor surfaces to a greater

extent than the flexors, leaving the palmar and plantar surfaces absolutely free. The scalp over the occiput, the forehead, the orbital margins and outer canthi, the alae nasi and nasal folds, and the margins of the lower jaw were also to a less extent affected, but the neck and trunk, except in the lumbar region behind, just above the level of the iliac crests, were very noticeably not involved.

The eruption consisted of three types of lesion: (1) Spots or patches of diffuse erythema; (2) cutaneous hæmorrhages, petechiæ and purpuric spots up to the size of a shilling-piece; (3) blebs of varying size, from small vesicles up to large, tense, rounded or oval bullæ with hæmorrhagic contents.

Over the areas where the eruption was most scanty, as over the cheeks, the shoulders, the front of the thighs and of the shins, isolated purpuric spots alone were seen. In the neighbourhoods of the knee and elbow, of the ankle and wrist, in the groins and axillæ, and over the dorsa of the hands and feet all three types of eruption were found. In these regions it was seen that the three types of eruption were arranged with the erythema highest, then came the petechiæ, and at the periphery the blood-blisters.

In development apparently the petechiæ first appeared; over these developed vesicles. The vesicles at first contained clear serous fluid, later their contents became hæmorrhagic. The vesicles then ran together to form "blood-blisters" of increasing size. The blood-blisters on the dorsa of the hands, over the backs of the wrists, elbows, and knees, and over the inner side of the ankles were the largest, reaching in some cases the enormous size of $2\frac{1}{2}$ in. in diameter. In the axillæ and groins and on the buttocks the largest blisters were $1\frac{1}{2}$ in. in diameter. The large blisters all contained blood-stained clear fluid.

Cultures taken from the smaller recent vesicles on January 9th yielded a pure culture of a short streptococcus bearing the characters of *Streptococcus pyogenes aureus*, possibly a contamination. No excess of eosinophile leucocytes were seen in films made from the contents of the blisters; polymorphonuclear neutrophiles and lymphocytes occurred in small numbers. Blood-cultures taken on the same day remained sterile.

The erythema was seen only in the larger patches of eruption, where the rash was most marked, and more especially over the upper

extremities. The distribution of the eruption is best studied from the annexed diagram. The isolated small black patches represent the purpuric spots.

The mucous membranes apparently were not directly affected, but the mouth and pharynx were extremely dry, denuded of epithelium, and covered with dried, blood-stained material.

The eruption upon her face, nose, and eyebrows, and to a less extent on her hands, had been subject to nail-scratching, and in these situations clotted scabs obscured the original lesions.

The heart's apex-beat was felt in the fifth space just inside the mid-clavicular line, the cardiac impulse was feeble but well localised; the heart-sounds were clear. There were no adventitious cardiac sounds.

The movements of the chest were limited, the air entry poor, the breath-sounds unaltered, and at this date no adventitious sounds were heard.

The abdomen moved fairly well on respiration. The liver was not enlarged and the spleen was not palpable. There was no vaginal discharge.

The urine was acid; 47 oz. were passed in the twenty-four hours following admission, with a specific gravity of 1020. On cooling this deposited urates but contained neither albumen nor blood.

The pupils were equal and reacted normally; the knee-jerks were obtainable.

Progress and treatment.—After admission the eruption extended considerably by the appearance of fresh petechiæ, new vesicles, and hæmorrhagic blisters. For four or five days the general condition remained typhoidal and extremely grave; on several occasions she seemed on the point of death, poisoned by the severity of the infection, her pulse at these times becoming very feeble, dicrotic, and "running."

Her chief complaint was of thirst and dryness of the mouth and throat. She took milk feeds readily.

On admission her limbs and the parts involved in the eruption were wrapped in spread boracic ointment. Calomel, saline aperients, and arsenic (liquor arsenicalis ℥v *ter in die*) were administered by mouth, and 20 c.c. polyvalent anti-streptococcic serum were given subcutaneously on January 8th and repeated again on the 11th. About the latter date her condition began to show signs of improvement, her mouth became less dry, her hebetude less severe, her

interest in her surroundings greater, and the daily crops of eruption smaller and non-bullous, whilst the affected parts scabbed over and gradually cleared.

At the same time her temperature, which till this time had been 98°–99° F., rose to 100° F.; a troublesome cough, unaccompanied by expectoration, but associated with pain in the left side of her chest, appeared, and she gave signs of partial consolidation over her left lower lobe accompanied by a dry pleuritic rub.

Albumin, in small traces up to a cloud, and small quantities of blood were passed in the urine on January 16th. The chest signs cleared rapidly, the albuminuria ceased, and by the 23rd the patient appeared well on the way to recovery. On the 24th a few fresh purpuric spots appeared for the first time on the trunk, and a few more on the 25th. After this date no fresh eruption appeared. Later the blisters on her left arm became purulent, but the secondary infection only spread over this forearm and hand. The places on her left buttock were the last to scab over.

At the present time (February 23rd) she is in the best of health, and presents again the appearance of a young person. She carries irregularly pigmented scars over her knees, her elbows, her forehead, and on her left buttock, whilst smaller non-pigmented scars appear elsewhere. The outer rim of her right ear is gone, whilst her left hand, which became secondarily infected with pyogenic organisms, carries thickened skin leading to some disability, a disability which under massage is rapidly improving, so that even here recovery bids fair to become absolute.

THE TECHNIQUE OF INTRAVENOUS INJECTIONS OF SALVARSAN.

By JAMES McINTOSH, M.D.Aberd.,
Grocers' Research Scholar; and

PAUL FILDES, M.B., B.C.Cantab.
(*From the Bacteriological Laboratory of the London Hospital*—Dr. W. Bulloch.)

In a method designed for intravenous injections of "606" it is desirable to include the advantages of simplicity and portability. These qualities are not to be found in most of the advertised instru-

ments. Our first intravenous injections were made with a 20 c.c. "Record" syringe and two-way tap on the principle of Schreiber; but, though this is a convenient method, we have found certain objections to it in practice. First is the difficulty in retaining the needle in the vein. The considerable weight of the syringe and the movements of the piston and tap are all liable to cause the sharp needle to penetrate the opposite wall of the vein, however still the operator may endeavour to hold the syringe, and however still the patient may lie. It has been proposed to counteract this danger by shortening the bevel of the needle-point and making it blunter, but it is well known to those who have had much experience of venepuncture that, in a difficult case, a sharp needle much increases the likelihood of success. Secondly, with a syringe only half the time of the operation is taken up with injecting; the other half is occupied in filling the syringe. There is, therefore, a tendency to hurry the injection, and this tendency manifests itself in the application of undue force to the piston with consequent dilatation of the vein. In this way some leakage may occur through the puncture in the vein and give rise to pain and infiltration, both of which, however, are usually trifling. The danger of injuring the vein by movements of the syringe has been met by the introduction of a length of rubber tubing between the two-way tap and the needle. We, however, prefer to dispense with the syringe entirely. The following is a short account of the method now employed in the wards of Dr. Sequeira, at the London Hospital. We do not claim in any way to have originated this method; we have no doubt that the simplicity of the principle has already commended itself to many, and, further, it has been adopted and published recently by Iversen, who has practised intravenous injections from the time of the first introduction of "606."

The solution is made up according to the makers' directions in a wide-mouthed sterile bottle of 300 c.c. capacity. The bottle contains some large beads (A), which have previously been thoroughly cleaned by boiling in an acid solution of bichromate of potash, washing in water and sterilising. These beads assist in the solution of the preparation. The bottle has either a rubber or ground-in glass stopper (B). When the solution has been prepared and warmed by standing the bottle in hot water the stopper is fastened in, and the injec-

tion fluid can be transported to the bedside for use within about one and a half hours. The actual apparatus consists of a rubber stopper (C), which is firmly "screwed" into the bottle. This stopper is perforated in two places. One perforation carries a T-piece, the vertical arm of which is connected to a cotton-wool air filter (D), and is controlled by a clip (E). The horizontal arm of the T-piece is connected with a rubber pump (F), and the air from this latter is sterilised by passage through a second glass tube containing cotton-wool (G). The second perforation through the cork carries a piece of tubing bent at the top (H), and leading to the needle. Below, this tube is carried to the bottom of the bottle by means of a rubber tube (K), carrying on its lower end a sinker of lead. A piece of thin glass tube (L) is carried immediately behind the needle-holder (M), and is connected thereto by rubber. The needle-holder is merely a metal tube of small bore, carrying wings on each side, and ground to fit at the end a "Record" needle. The wings are intended to lie flat on the patient's arm and to act as a handle. The length of the needle is one inch to the point and rather less than 1 mm. in diameter. With the exception of the pump, the needle and the two tubes (D and G) plugged with cotton-wool, the whole of this apparatus can be boiled, drained, and enclosed in a small sterile waterproof bag. The two filters (D and G) may be sterilised by passing through a flame before the wool is inserted, but they should not be put into position until the apparatus is assembled for use, as the wool must be kept dry. The needles are best kept in a small porcelain crucible containing olive oil. When required the temperature of the oil is raised to about 130° C.; the needle is then removed and enclosed for transport in a piece of sterile lint.

The injection is made as follows. "Screw" the stopper (C) firmly into the bottle containing the solution of "606." Insert the two filters (D and G) and attach the pump (F). Close the clip (E), and put a clip (N) on the tube leading to the needle. Hold the needle-holder vertically above the bottle. Give two or three pumps, and by momentarily releasing the clip (N) expel the air from the tubes. Attach the needle to the holder and again expel the air by momentarily releasing the clip (N). All air is expelled when the fluid escapes freely from the needle-point, but, in any case, small bubbles are of no importance. Next, keeping the clip (N) in position, open the clip (E) for a few

moments to relieve pressure in the bottle. A tourniquet having been placed on the patient's arm, so that the veins stand out, sterilise the skin and push the needle into a vein with the bevel *down*. Remove the clip (N) entirely. The pressure in the vein will cause the blood to appear at the window (L). The needle must then lie in the vein. Next fasten the needle in position by laying a strip of adhesive plaster across the wings of the holder (M), these wings having been arranged

to lie flat on the arm when the bevel of the needle is down. The strapping may, conveniently, be applied to the skin on one side before the needle is inserted and afterwards carried across to the other side. Release the tourniquet and give three or four pumps, and the blood will soon be seen to be washed from the window (L), and the injection will proceed without any trouble other than four or five applications of the pump. Three hundred c.c. are introduced in from six to nine minutes. At the end re-apply the clip (N). Release pressure by opening the clip (E) and remove the needle. Press upon the puncture and hold the arm in a vertical position for a moment or two. No

dressing is applied, but the arm is wrapped in a clean towel and flexion of the forearm is not allowed for one hour.

An advantage of the method detailed above is that the position of the needle in the vein cannot be altered, and since the proximal end of the holder is held applied to the skin the distal end of the needle is held up to the superficial wall of the vein, and since the bevel of the needle is *down* its orifice is clear and unobstructed. Further, although the injection is more rapid than with a syringe, no undue force is applied, the vein is not distended, and no leakage occurs. Lastly, since the needle-holder is so light, it requires greater force to perforate the opposite wall of the vein than with a heavy syringe.

The success of a venepuncture depends largely upon the condition of the vein and the position of the light by which the operation is performed. This must be held at right angles to the line of the vein and low down to give greater relief. It is also necessary to obtain a maximum prominence and distension of the vein to facilitate entry

and to force the blood to appear readily at the window. If distension cannot be obtained sufficiently to secure this latter effect, the clip (x) can be put upon the tube leading from the pump and slight suction can be applied at the filter (d) with the mouth; then, if the needle is in the vein, the blood must appear at the window (L). Engorgement of the veins cannot be obtained readily by a circular application of a bandage. The best method is as follows: Pass a piece of three-inch bandage behind the arm and bring the two ends to the front; then, pulling very tightly, cross and reverse the ends, and carry them round again to meet on the outer side of the limb. Here tie a bow. In order to avoid pinching the skin under the point of reversal, place here a "swab" between the knot and the skin. The veins can be made still more prominent by repeated clenching of the fist and by rubbing with ether during the process of sterilisation.

The whole of the apparatus described above can be readily enclosed in a case 6 in. by 6 in. by 3 in., and this case can be carried in an ordinary hand-bag.

ROYAL SOCIETY OF MEDICINE.

DERMATOLOGICAL SECTION.

Meeting held on Thursday, March 16th, Dr. T. Colcott Fox, President, in the Chair.

Dr. H. G. Adamson showed *two cases of Adenoma sebaceum in mother and son.* In the mother, aged 31 years, the lesions dated from birth, though they had increased in size. They were typical lesions of the Pringle type—hemp-seed-sized, smooth, oval, yellowish, with a network of fine vessels giving them a red tinge, and situated on the cheeks at either side of the nose. There was much diffuse telangiectasis of the cheeks and nose.

The son, now aged 5 years, showed red spots on the cheeks and sides of the nose when four years old. They were now pin-head-sized, and were gradually getting larger. The yellow colour, seen on pressure, was marked by telangiectases. On the forehead there was

a flat, irregular swelling, probably a soft mole. The boy's body was covered with numerous small whitish elevations, looking like plane warts, but soft to the touch. Some were apparently lobulated, suggestive of a sebaceous gland origin, though their nature could not be determined without microscopical examination, to which the mother would not consent. There were also about half-a-dozen finger-nail-sized oval leucodermic patches about the trunk.

The boy's elder brother, aged 8 years, had no skin-lesions. The mother and child seemed to be of normal intelligence, and there was no history of epilepsy in the family.

The cases were of interest because they were in mother and child, which was, the exhibitor thought, an unusual occurrence.* Also on account of the multiple small elevations on the boy's body.

Dr. Galloway inquired whether a more satisfactory treatment had been suggested for this condition than electrolysis? This was a very wearisome and painful procedure, and produced very little good result in such cases. A doctor had brought his son, a bright, intelligent lad of about fourteen, to him with well-marked Adenoma sebaceum. The father had treated the boy by means of electrolysis, but with little or no improvement. Dr. Galloway suggested in this case the use of solid carbon dioxide, and the boy was now undergoing treatment by his father by this method. He hoped the results would be more satisfactory.

Dr. Dore showed (1) *a case for diagnosis*. The patient was a man, aged 41 years, who had suffered from a lesion in the right groin, which from time to time had ulcerated in part of its extent during the past fourteen months. The lesion was situated just above and parallel to Poupart's ligament, and consisted of an oval patch of a reddish-brown colour about three inches long and half an inch wide in its greatest diameter. The surface was smooth, and apparently uniform in colour, but on stretching the skin some rounded whiter areas could be discerned at the inner part. At the outer extremity there had been an ulcer about half an inch in length; this had recently healed under iodide of potassium, but it had healed several times previously without treatment.

The patient had contracted syphilis twenty-one years ago, and the exhibitor at first regarded the lesion as a late syphilitic manifesta-

* Since these cases were shown the exhibitor has found a note by Dr. Stopford Taylor and Dr. Barendt on "Three Cases of Adenoma Sebaceum in One Family," *Brit. Journ. Derm.*, vol. v, 1893, p. 360.

tion, but the recent appearance of what seemed to be an initial lesion resembling a lupus nodule led him to regard it as tuberculous. Another recent phenomenon was the appearance of distinct infiltration at the lower and outer part of the patch. Wassermann's test had not been carried out on account of the previous history of syphilis.

Dr. PRINGLE thought that the lesion was probably a relapse syphilide *in loco*, and suggested that a Wassermann test should be made. If positive, it was evidence that he still had active syphilis, even after so long an interval, and he would be inclined to act on the result of the test.

Dr. WHITFIELD said that three diseases had occurred to him, namely, Paget's disease, morphœa, and syphilis. Close examination convinced him that it was not the first, and on the whole he thought it most probable that it was a patch of morphœa. Ulceration was not uncommon if a patch of morphœa was irritated.

Sir MALCOLM MORRIS agreed with Dr. Whitfield that it was more like morphœa.

Dr. PERNET expressed the view that the condition was syphilitic.

(2) A case of *moniletlirix* in a male child, aged 16 months. An older member of the family, suffering from the same disease, who was shown at the April meeting of the Dermatological Section, 1910, was also brought to the meeting. When the latter was exhibited a year ago the scalp of the child now presented was apparently normal. The mother dated the condition from four or five months of age, when she first noticed that the hair at the back and sides of the child's head was not growing properly. The disease in the present case resembled that of the older child as regards its distribution and the appearance of the hairs, but differed from it in the slight degree of keratosis of the mouths of the hair-follicles, which was concurrent with the growth of moniliform hairs, and had not preceded it as in the other case. This child was born at full term, the elder brother prematurely. Both suffered from rickets. Microscopical specimens showed the fusiform nodes or spindles alternating with constrictions at more or less regular intervals according to the degree to which the hairs were affected. In unstained specimens the cuticle was seen to be thickened at the internodes, which presented the usual brush-like extremity on fracture, but there did not appear to be a deficiency of pigment in this position, nor an increase of that at the nodes. Many of the latter, however, showed a deeply pigmented fusiform medulla which was absent altogether in the constricted portions.

Dr. Galloway said that he had had at one time two cases of monilethrix occurring in brothers under observation for some years. The other children of the family were unaffected. As the boys grew older the affection of the scalp became less obvious, as the unaffected hairs grew and covered over the shorter fragile hairs affected by the disease. He gained the impression that the originally affected hairs did not recover.

Dr. Colcott Fox exhibited a child, aged 16 months, who came under his care with well-marked *ichthyosis* a few weeks ago, and in whom a remarkable amelioration had occurred by the local application of glycerine and water, and the ingestion of ½ gr. of thyroid extract, at first twice daily and later thrice daily. He could not help thinking a great deal of the improvement was due to the thyroid extract. He could not detect any thyroid gland in the child. His object in exhibiting the child was to elicit the experience of the Section in the treatment of ichthyosis by thyroid extract. His own experience had been favourable and others had reported satisfactory results.

He pointed out the desirability of investigating the condition of the thyroid glands in such cases when opportunity arose. The cases in which the condition had been reported were very scanty. In a *Thèse de Lyon* by Paul Rion, 1908, the author reported that in sixty cases of fœtal ichthyosis, in which an autopsy was made, the state of the thyroid gland was only mentioned three times; in one it was found healthy, in one totally absent, and in a third altered by sclerosis. Of its state in common ichthyosis we know practically nothing by autopsy, but in six cases the thyroid gland could not be detected, and in four cases the patients had goitre.

Dr. Pringle said he was familiar with the case of ichthyosis reported by Winfield in which the thyroid was found to be absent; he thought, however, that such an occurrence must be very inconstant. He was able to confirm the President's experience of the extraordinary improvement of such cases under thyroid feeding, and was, on the whole, surprised at the amount of thyroid gland substance which even young children could often take with advantage.

Sir Malcolm Morris remarked that young children bore thyroid very well for other conditions also. He had been administering it in small doses to young children for persistent acute eczema, and recently he read of it being given by others for the same disease, and with equally good result.

Dr. Galloway said that the President would no doubt remember various reports and, among others, a thesis for the M.D. of Glasgow by Dr. Don on the treatment of skin-diseases by thyroid extract. These reports were issued in the earlier days of the use of thyroid extract in the treatment of myxœdema. Many of the cases treated were cases of ichthyosis, and occasionally with some benefit.

He regarded the absence of the thyroid as quite an inconstant feature in cases of ichthyosis, and it was often very difficult to tell on palpation whether the thyroid gland was diminished in size or not. It was, however, quite possible that the function of the thyroid gland might be diminished, and in these cases no doubt the administration of thyroid extract would prove beneficial.

Dr. Sequeira did not remember to have seen ichthyosis in cretins, because that should be so if the idea which had been expressed were correct.

Dr. Pernet reminded members that the late Dr. Radcliffe-Crocker and he had given, for some time past, thyroid extract in cases of ichthyosis. The treatment was mentioned in the third edition of Radcliffe-Crocker's work.

Dr. MacLeod said that he had treated several cases of ichthyosis in young children with thyroid extract with marked benefit. He found that great care had to be exercised in regard to the dosage, and referred to one unfortunate experience where severe tachycardia was produced in a boy, aged 6 years, suffering from mild ichthyosis by doses of 1 gr. daily.

Dr. Graham Little showed (1) a *case for diagnosis*. The patient was a chemist's assistant, aged 37 years, living in Cardiff, who had been sent to the exhibitor for treatment by Dr. Pine, of that city. He had, when first seen, a very extensive and quite scaly, ringed eruption covering the shoulders, arms, chest, thighs, and buttocks; there was very much itching as well. The face and scalp were free. The rings were about the size of a shilling, and the borders elevated and scaly, the central skin not apparently much altered. The eruption had lasted for three months. He had been treated with one application of sulphur ointment some weeks ago, under the supposition that he had scabies, and he had suffered so much discomfort from the one application that he had changed his doctor, and was now under the care of Dr. Pine. The man had had syphilis thirteen years ago, and had had treatment for three years with mercury and iodides; he had had three children since, all of them quite free from syphilitic taint.

The exhibitor had formed the opinion that it was a case of Pityriasis rosea, but had been doubtful of the diagnosis because of the duration of the eruption—full activity after a lapse of three months being in his experience very uncommon—because of the excessive scaling and the degree of itching, which was extremely severe.

(2) A case of *nævi of peculiar appearance*. The patient was a girl, aged 12 years. The mother stated that the child was born quite free

from eruption of any kind; this had begun to appear at the age of about eight or nine months. The distribution and appearance at the present time was as follows:

On the right side of the neck, over the front border of the sterno-mastoid, there was a small group of pink, flattened, and in some cases scratched papules. On the inner side of the left arm, running down in a straight line from the elbow to the wrist along the free edge of the ulna, there was a similar collection of papules, pink and inflammatory. On the outer side of the right chest, at a point about midway between axilla and iliac crest, there was a similar small group of papules covering an area about the size of a florin. On the front of the thigh there was an area the size of the palm of the hand, immediately below Poupart's ligament, covered with very numerous horizontal and vertical lines of papules running down on the thigh for a distance of about 6 in., the lines intersecting in parts to form a mesh-work. The papules were pink, some excoriated, and at first sight rather like Lichen planus. A single line starting from the network on the upper part of the thigh was continued with intermissions down the thigh to the level of the calf of the leg, and here for the first time the line became slightly flecked with brown pigment. The curiously inflammatory aspect of the lesions, their restriction to the right side and the multiplicity of sites affected were points of interest in this case. The onset of the lesion so many months after birth, if the history could be relied on, was also peculiar.

Dr. MacLeod showed a case of *keloids forming on the cicatrices resulting from ulcerating syphilitic lesions.* The patient was a labourer, aged 31 years, who had contracted syphilis twelve years ago. Five years ago, while serving in the Army in Sierra Leone, ulcerated, crusted syphilides had appeared on his arms and buttocks, on account of which he was taken into hospital and treated for six months with injections of mercury. On being discharged he was kept under supervision and treatment for about two years. At the time of exhibition he had a number of raised brownish patches, irregular in outline, with a prominent border, and varying in size up to three or four inches in diameter, situated on the arms, trunk, buttocks, and legs. In addition to these lesions a number of small cicatrices, about the size of a sixpence, white, pitted, and tissue-paper-

like, were present on the left buttock and arm. On several of those on the arm were small red keloidal thickenings. The patient was unable to tell when those first appeared, as he had not noticed them until they were pointed out to him by the exhibitor. On the front of his chest an elaborate design in red and blue had been tattooed, and here and there fibrous thickenings were present on the red marks.

The PRESIDENT said it was a nice point in the case as to whether the condition was true keloid or hypertrophic scar-tissue. In his own experience the multiple hypertrophic scars of a generalised syphilide tended to resolve spontaneously, and were not true keloids.

Dr. PERNET said he regarded the case as one of hypertrophic scarring, not as true keloid. He had now seen a number of cases of hypertrophied scarring in syphilis. It was the result of secondary staphylococcal infection.

Mr. MCDONAGH said he showed a case before the Section with keloids all over the body, many of which had disappeared spontaneously.

Dr. GRAHAM LITTLE recalled a case shown by Mr. Arthur Shillitoe to the Dermatological Society of Great Britain in 1903, in which the patient, a man of middle age, had developed hundreds of apparently keloid growths on the site of rupial sores. The tumours were the size of a Barcelona nut. Dr. Little had obtained a section from one of these, and found histologically the appearances characteristic of scar-keloid, namely, thinned epidermis, obliteration of the glands and hair-follicles, and immediately below the epidermis masses of fibrous tissue arranged in bundles parallel with the line of the epidermis. Nevertheless, this case had also spontaneously recovered, the tumours all disappearing some months later.

Mr. J. E. R. MCDONAGH showed a case of *congenital xanthoma (endothelioma)*. D. H—, a girl, aged 5 months, the first and only child, was brought up to the hospital by her mother for some swellings in the skin. These had made their first appearance fourteen days after birth, the skin being quite normal at birth. The swellings which were scattered over the body without any predilection for site, were about the size of a lentil when they appeared and red in colour. Many of these disappeared spontaneously, becoming yellow before doing so, and as soon as some had vanished fresh lesions made their appearance. The mother stated that she was born with similar swellings, which came and went up to the age of fourteen—there was no sign at the time of examination. Although the lesions resembled clinically those met with in a case shown by the exhibitor before the Society in June, 1909, they differed in that they

were not present at birth, and that some fresh lesions appeared after the initial outbreak, but the tendency to spontaneous cure was characteristic of both. Histologically the tumour was a new growth composed mainly of endothelial cells and fixed connective-tissue cells.

There were some giant-cells in the subpapillary layer of the cutis, which the exhibitor regarded as being capillaries blocked by an aggregation of endothelial cells, since, with a high power, distinct cells with faintly stained nuclei could be made out, and in those where the occlusion was not complete red blood-corpuscles were visible.

These giant-cells and the endothelial cells around them and the fixed connective-tissue cells contained small particles of fat, which stained well with Sudan III, but brownish-black instead of black with osmic acid; therefore the fat was considered to be not a true fat.

Owing to the frequent occurrence of angiomata amongst the xanthoma lesions and the histological appearances of the two cases the exhibitor looked upon the disease as being a new growth, probably of that portion of the mesoblast which was destined to form the walls of the capillaries—an endothelioma.

The exhibitor was greatly indebted to Drs. Thursfield and Adamson for the case.

Dr. Galloway asked whether any recent account of the histology of xanthoma occurring in glycosuria, or associated with visceral disease, had been published. There could be no doubt of the possibility of the disappearance of nodules of xanthoma. He had shown a case to the Section of xanthoma in a young man affected with severe diabetes, in whom the tumours disappeared under observation while he was being treated as an in-patient in the hospital.

Sir Malcolm Morris said he recently saw, in a gentleman from Southampton, a severe case of xanthoma diabeticorum, in whose urine there was no sugar, nor did there ever appear to have been. About a week after he had been put on anti-diabetic diet many of the lesions had disappeared.

Dr. Sequeira read for Dr. Parkes Weber the following note: The case shown by Dr. Parkes Weber at the Dermatological Section on May 21st, 1908, as a case of *multiple xanthoma in an infant*, exactly resembled Mr. McDonagh's case in the naked-eye appearance of the lesions. At the meeting it was suggested that the case might be one of Urticaria pigmentosa, but Dr. Graham Little afterwards examined one of the lesions microscopically and told Dr. Weber that it was certainly not Urticaria pigmentosa. The lesions in Dr. Weber's case had since then disappeared spontaneously.

Dr. Sequeira showed (1) for diagnosis a case of (?) *Mycosis fungoides*. The patient, a dairyman, aged 48 years, was born in Wales, but had lived for the past twenty-five years in the East End of London. He had had no previous illness, and denied ever having syphilis. The Wassermann reaction was negative. The patient has two children in good health.

Two years ago, in the summer, he had an outbreak of "boils" on various parts of his body. These lasted a short time and disappeared under treatment administered by his private doctor. Fifteen months ago he had an attack of what he called "pimples" on both knees. These spread and were accompanied by intense itching. The scratching consequent upon this eruption seemed to aggravate the condition, and he saw a medical man, who informed him that he had "poisoned" the places with dirt from his fingers. He was treated with ointments and lotions for a month, but without benefit. A rash then appeared on the back and shoulders; this also was accompanied by intense itching, which has characterised the disease throughout. The rash gradually spread until almost the whole of the body was involved.

During the summer of 1910 he suffered from excessive sweating, his clothes being soaked in perspiration if he took the least exercise. He was also conscious of sudden flushes about the body, accompanied by free sweating, these flushes being independent of exercise. He consulted various medical men, one of whom told him that the affection was dependent upon "change of life," and that it would pass off naturally in a year or two.

In October, 1910, he consulted Dr. Sequeira, and his condition then was similar to that now present. There were numerous red, fairly well-defined, slightly scaly patches, some of them as large as the palm of the hand, and others even larger on the trunk and extremities, particularly on the shoulders, the loins, buttocks, abdomen, inner and back surfaces of the thighs, the fronts of the legs, and to a less extent on the flexor surfaces of the upper extremities. There was one small patch on the right cheek, but the rest of the face and scalp were unaffected. In many places the surfaces showed abrasions and linear scratch-marks, for the pruritus was described as being intolerable.

There was nothing in the manner of the patient's living to account

for the condition. He was a moderate drinker, and did not smoke, and he has taken usually the plainest of food.

In October, 1910, on the assumption that the condition was most likely a pre-tumour stage of Mycosis fungoides, Dr. Sequeira ordered a course of X-ray treatment, which benefited the patient considerably, and for a time relieved the itching entirely. The pruritus has returned as badly as ever during the past two months, and the patient was brought to the meeting for a confirmation of the diagnosis, which had been made provisionally.

The blood examination showed nothing abnormal, and there has been no enlargement of the lymphatic glands or of the spleen. The pruritus interfered so much with the patient's sleep that it had induced a nervous condition, intense irritability, and inability to perform the usual routine of his work.

It was proposed to continue the X-ray treatment.

Dr. PRINGLE thought the large lesions were eminently suggestive of Mycosis fungoides, having seen a considerable number of similar cases.

Dr. PERNET regarded the case as one of early Mycosis fungoides.

(2) A case of *alopecia of acquired syphilis* in a boy, aged 7 years. On February 21st the patient was brought by his mother to the London Hospital on account of the loss of hair, which had been attributed to ringworm, and for which the child was excluded from school. The mother and father and the five other children are said to have good health.

On examination the boy was found to be anæmic and rather thin. He had numerous spots of impetigo, dried crusts on the scalp and the back of the neck. The glands behind the ears and the angles of the lower jaw were enlarged and very hard. The epitrochlear glands, and also the glands in the supra-clavicular fossæ, axillæ and groins were also enlarged and shotty. A rash consisting of dusky red, slightly raised and infiltrated papules was scattered over the shoulders and the upper two thirds of the back. There were also two small, dull-red scaly patches on the front of the chest, just above the ensiform cartilage, and another on the front of the bend of the right elbow. There was no iritis or choroiditis and the mouth and throat were free from ulceration. The alopecia was of

the character met with in secondary acquired syphilis, and is well illustrated in the accompanying photograph.

It was difficult to determine the site of the primary sore. The genitals were free from any evidence of syphilis, and the presence of a large gland behind the sterno-mastoid muscles suggested that the primary inoculation had occurred in one of the spots of impetigo at

the back of the neck. A positive reaction to the Wassermann test confirmed the diagnosis.

(3) A case of *Lichen planus* of unusual distribution. E. W—, aged 34 years, a married woman, came to the London Hospital complaining of a rash upon her body. She gave the following history: About a week before Christmas, 1910, she noticed a few spots, which itched, upon the back of her neck. These increased in number until a large patch between her shoulders was covered. A similar eruption then appeared upon her chest and abdomen. The itching was not severe except at night.

The patient was rather anæmic, but she described her general health as being good. She had no other trouble than the rash.

There was no history of mental stress recently, though she was confined eleven months ago and was still suckling her infant.

The rash was characteristic, consisting of groups of flat papules with burnished surface, with sepia-tinted pigmentation in the sites of the areas which had cleared up. The distribution of the eruption was unusual, it being limited to the middle line of the back between the shoulders and spreading out below in the loin. The areas at once suggested the distribution of the seborrhoides, and this likeness was also manifest upon the chest, where the intermammary and submammary regions were also involved. Around the waist the usual effect of the pressure of the corset was shown in the increase in the number of patches of papules. There were a few spots upon the left thigh, but the fronts of the forearms and legs and the thighs were otherwise quite free. There were a few small white spots (papules) on the buccal mucosa. The case was shown on account of the uncommon distribution.

Sir Malcolm Morris said he had seen several such cases post-mortem, and in one case particularly, in which abdominal section was done, the peritoneum was covered with warty vegetations associated with that form of Lichen planus

with deep pigmentation. He believed there was a difference between that form and those kinds of Lichen planus which were not so much pigmented.

Drs. Ashton Warner and Wilfrid Fox gave a further report on a case shown by them before the Section in December last (*vide* p. 26, *British Journal of Dermatology*, January, 1911). The case was then somewhat obscure as to its nature, and several members expressed a desire to hear a further report. The patient has since died, and the diagnosis appears to be that of an unusual *sarcoma*.

Since the members of the Section saw the patient in December nothing of much importance happened until February 8th. During that time the patient never felt very well, however, and complained that the nodules in the skin were rather more itchy. One or two fresh ones came out on the hands where they had not been before, and some of the others disappeared in the same way as previously described. On February 8th the patient complained of a cough and a certain amount of discomfort in breathing, but there was no rise of temperature and very little abnormal to be discovered in the chest. On February 10th the dyspnœa decidedly increased; the left side of the chest was found to be dull, but the dulness at that time did not appear to be indicative of fluid, and the breath-sounds could still be heard, although distant—the position of the heart was normal. On February 12th the dulness was very much more evident, the heart was pushed over into the right chest, and on tapping the left side twenty ounces of blood-stained fluid were drawn off. This did not, however, relieve the dyspnœa, nor did the heart go back to its normal situation. At this date, also, one single enlarged vein was observed running down the front of the chest. On February 15th the patient's difficulty in breathing still continued, and fourteen more ounces of fluid was withdrawn from the left side, which, however, gave no relief. This condition continued, the dyspnœa gradually increasing until February 18th, when the patient died. It was found impossible to have a post-mortem examination made, so that the absolute diagnosis of a mediastinal growth is not completely established, but clinically there appears to be very little doubt that this was present.

It appeared that we had in this case a type of sarcoma in the skin which, although clinically of that condition, microscopically could not be recognised as such by the many competent pathologists who were kind enough to examine the slides.

Dr. Bertrand Dawson saw the patient on two occasions with Mr. Warner during the last few days of the illness, and agreed that the symptoms were most probably due to a mediastinal growth. The fluid from the chest was examined by Dr. John Matthews, who reported that it contained nothing of any diagnostic value.

Sir Malcolm Morris said he considered the case was clinically a sarcoma, even though the microscope did not appear to support that view. He thought the Section was much indebted to Dr. Warner and Dr. Wilfrid Fox for having given the after-history.

Dr. Galloway asked whether there was any palpable enlargement of lymphatic glands in this case. He had seen a patient who had been under the case of Dr. Hebb and Dr. Colcott Fox at the Westminster Hospital, in whom there had occurred numerous nodules in the skin of the peculiar violaceous tint shown in Dr. Wilfrid Fox's drawing. This case was one of true Hodgkin's disease, and the skin-tumours were examples of lymphadenoma showing the same structure as the enlarged lymphatic glands. Cases of Hodgkin's disease occurred with little or no enlargement of the superficial lymphatic glands, but showing great enlargement of the internal lymphatic structures. It was possible that enlargement of lymphatic glands of the Hodgkin's type in the mediastinum might affect the pleura and so produce effusions such as Dr. Wilfrid Fox described.

Dr. Whitfield said that pseudo-leukæmic prurigo had nothing in common with lymphadenomatous growths in the skin. The latter were large nodes and not irritable in his experience. He agreed that in Dr. Wilfrid Fox's case the tumours did not resemble Lymphadenoma cutis either clinically or histologically.

The President said he saw some time ago a man in his out patient department with lymphadenoma and intense generalised itching of the skin, but there was no eruption. Later a profuse eruption developed indistinguishable from prurigo but associated with larger leukæmic growths. This case might be taken as a proof that the "prurigo" was excited by the scratching for the relief of the pruritus, but on the other hand such a conclusion might be fallacious.

CURRENT LITERATURE.

NODULAR TUBERCULOSIS OF THE HYPODERM. Grover W. Wende. (*Journ. of Cut. Dis.*, xxix, No. 1, vol. i.)

The patient, an Englishwoman, aged 43 years, was engaged as a washerwoman. She had been in America five years. The family history was unexceptionable. The patient had measles, scarlet fever and smallpox in childhood, and acute articular rheumatism when twenty-five years of age. In January, 1903, while still in England, a lump the size of a hickory nut appeared at the junction of the coronal and sagittal sutures. The onset was attended with pain. The tumour slowly enlarged, but there was no redness or scaling of the skin. In two to three months it had extended in linear fashion towards the right temple. The growth

then underwent a slow resolution and left no scar. Soon after a new lump began to appear behind the right ear, and reached the size of a pigeon's egg. This remained the same size for three months and was accompanied by pain and deafness. There was no otorrhœa, but the patient complained of tinnitus. Before this lump disappeared the cheek over the right temporo-maxillary articulation was attacked, causing almost complete ankylosis (!), which has persisted to some extent ever since. Lumps lasting from two to eight months continued to come and go, the patient never being free from them. They were always on the same side and tended to form groups. From the cheek the condition gradually extended to the chin, and for six months previous to her coming under observation they began to develop on the left side.

The patient's general condition was excellent throughout. On January 1st, 1909, the skin was exempt from scars, pigmentation, or atrophy. The chin felt as if it contained a small collection of marbles, varying in size from a pea to a pigeon's egg, all situated in the subcutaneous tissue. The nodules were painful to touch and felt like cartilage. The skin over the largest tumours was glistening red, but otherwise there was no superficial change.

A year later, January 1st, 1910, the lesions had practically disappeared from the right side and now extended round the mouth, forming a ridge resembling cartilage about an inch wide. In close relation were three nodules of four weeks' duration.

Microscopical examination of one of the smaller lesions showed that the lobes and lobules of fat and the septa had been replaced by infiltration consisting mostly of round-cells, between which were occasionally accumulations of epithelioid cells. In the centre of the nodule there were many multinucleated cells and some typical giant-cells containing acid-fast bacilli. The tubercle bacilli were also seen outside some of the cells.

The structure resembled in some respects Erythema induratum. There were numerous polynuclear cells and lymphocytes, and a number of plasma-cells. Cellular infiltration was present round the vessels and seemed to follow their course.

Calmette's reaction was markedly positive in four hours, and the skin lesions apparently also reacted to the tuberculin solution applied to the eye.

In one guinea-pig (of three) inoculated with the material a general tuberculosis of the lungs and spleen and mesenteric and bronchial glands developed.

The nature of the case was not suspected until the microscopical examination. Injections of tuberculin were followed by a pronounced shrinkage of the tumours.

J. H. Sequeira.

MYCOSIS FUNGOIDES. Lucius C. Pardee and F. Robert Zeit. (*Journ. of Cut. Dis.*, xxix, No. 1, p. 7.)

The subject of this memoir was a widow, aged 57 years. The family and personal histories were unimportant. Two years before she first came under Dr. Pardee's observation she noticed a bluish-red swelling upon each leg between the knee and ankle. This erythema, however, disappeared entirely, but was succeeded by a general pruritus which lasted a year. On examination she was somewhat enfeebled and had muscular tremor on exertion. The spleen was enlarged, but there was no other evidence of visceral disease.

The skin was yellow, suggesting the onset of jaundice, but the sclerotics were then unaffected. Upon the legs, thighs, and arms there was a symmetrical eruption of plaques and patches of a dull brownish or yellowish-red colour, with sharply defined outlines and surfaces covered with adherent scales. There were also a few patches of a deep venous blood colour. The plaques varied from a quarter of a dollar to several inches in extent.

The case was diagnosed as Mycosis fungoides, and in this diagnosis the members of the Chicago Dermatological Society concurred.

The X-ray treatment was carried out, and arsenic was administered. During the last month of life the tumours developed rapidly and new ones appeared. One on the left elbow was as large as half a cocoanut, and another closed the right eye. The superficial lymphatic glands were everywhere enlarged.

Some of the tumours underwent superficial ulceration. Towards the end the entire skin and sclerotics became deeply jaundiced and the site of innumerable capillary hæmorrhages. The blood-count, three weeks before dissolution, was 1,600,000 red and 5000 white cells, but the leucocytic counts rose rapidly just before death.

A very complete report of the autopsy is given by Prof. Zeit. He found lymphatic leukæmia with hyperplasia of the spleen, cervical, axillary, inguinal, mediastinal, bronchial, cœliac, mesenteric, and retro-peritoneal lymphatic glands, and leukæmic lymphomata in the lungs, skin, liver, spleen, and intestines. There were general jaundice, brown atrophy of the heart, and acute parenchymatous degeneration of the kidneys, chronic cholecystitis, and a submucous fibroid of the uterus. The bacteriological examination showed only *Bacillus coli communis*.

The histological characters of the tumours in the skin and internal organs differed from those seen in most cases of Mycosis fungoides. The multiplicity of cell-formation was absent, the pathological infiltration being made up wholly of mononuclear cells which had the typical aspect of lymphocytes. This hyperplasia of lymphoid cells was uniform and was found wherever lymphoid tissue normally occurs. The case is an important one, and its naked-eye and histological characters are well illustrated by plates. The pathological findings certainly suggest a true lymphatic leukæmia, but the clinical picture was indistinguishable from Mycosis fungoides. The writers conclude that Mycosis fungoides is an a-lymphæmic lymphomatosis, that is, a chronic lymphatic leukæmia. It is, therefore, primarily a disease of the hæmapoietic system, characterised by marked hyperplasia of lymphoid tissue wherever it is physiologically present.

J. H. SEQUEIRA.

AN UNUSUAL CASE OF TINEA VERSICOLOR. ERNEST L. MCEWEN. (*Journ. of Cut. Dis.*, xxix. 1, p. 19.)

THE special feature of this case was the development of papular lesions. The patient was a man, aged 27 years, with incipient phthisis. He had had the skin-eruption for twelve years. The trunk and upper limbs were affected. On the arms and chest there were the characteristic lesions of Tinea versicolor, but between some of the areas, especially on the back, there were discrete, flat-topped papules of a reddish-brown colour, hemp-seed to split-pea in size, follicular in location, usually pierced by a hair. The elevation was distinct to the eye and

finger. The papules could be removed by a curette, leaving the subjacent skin pale and non-inflammatory. The *débris* thus removed showed under the microscope masses of the Microsporon furfur. The condition is illustrated by photographs.

J. H. Sequeira.

FURTHER RESEARCHES ON THE HYPHO-MYCETES OF TINEA IMBRICATA. Aldo Castellani. (*Journ. of Tropical Med. and Hygiene*, March 15th, 1911, p. 81.)

In a previous paper on this subject, Castellani stated that he had isolated a fungus from cases of Tinea imbricata in Ceylon, which he had grown on artificial media, and had successfully inoculated on a human being. This fungus was named the "Endodermophyton concentricum (Blanchard)." Further researches have convinced him of the plurality of the fungi in this type of ringworm, and in Ceylon he has found another species in several cases, to which he has applied the name of E. indicum. The Endodermophyton concentricum has the following characteristics: Extemporary preparations in liq. potass. from scales show a felt of interlacing mycelial tubes, the segments of which are somewhat square in shape and usually straight. On glucose agar the growth in about fifteen days is abundant, and its surface cerebriform and crinkled, with no duvet, both the growth and the medium showing a slight amber tint, which later assumes a deeper hue.

The microscopical appearances of Endodermophyton indicum are identical with those of the other fungus, but there are slight cultural differences. On glucose agar the growth is abundant, the surface convoluted or furrowed, of a pinkish-orange or deep orange colour in the centre, the rest of the growth being white, powdery, and covered by a short, delicate duvet.

Photographs showing the typical lesions produced on a native by the inoculation of a culture are appended. The lesions developed after two weeks at the sites of inoculation.

The name "endodermophytons" was introduced by Castellani to denote the hypho-mycetes of Tinea imbricata and Tinea intersecta, which are characterised by their growing between the superficial and deep strata of the epidermis, forming an interlacing felt of mycelium, which detaches the horny and granular layers from the rete Malpighii; they do not invade the hair-follicles and do not cause suppuration.

J. M. H. M.

ZAMBESI ULCER. W. J. Bruce. (*Journ. of Tropical Med. and Hyg.*, January 2nd, 1911, p. 1.)

In the Zambesi delta a troublesome type of ulcer is prevalent among the natives. It is usually present on the foot or lower part of the leg, and chiefly attacks field workers, who are particularly liable to get cuts and scratches in these situations. In its typical form it is "a single, shallow, punched-out, round or oval ulcer, about the size of a florin, with a slightly undermined edge, a soft base, and a flat, purple-coloured floor." It is occasionally small, and in rare instances may be multiple. It begins as a tender œdematous swelling, which in twenty-four hours breaks down in the form of a slough, which disintegrates, leaving

a superficial cavity. In the course of a few days the swelling begins to subside, and in a few weeks healing takes place by granulation. Should the toe be attacked the ulcer may heal without terminating the disease, which results in a marked swelling of the foot which breaks down somewhere else. No specific micro-organism has as yet been isolated to account for the lesions.

J. M. H. M.

LEUCOPLAKIA AND KRAUROSIS OF THE MUCOUS MEMBRANE AND SKIN. Carl Bohač. (*Archiv f. Derm. u. Syph.*, Bd. cv, Heft 1 and 2, p. 179.)

Opinions have always varied as to the degree of the relationship which exists between syphilis and leucoplakia of the mouth. Erb reckons that syphilis accounts for leucoplakia in 79·85 per cent., Neisser in 65 per cent., and Joseph in 42 per cent., while other observers, on the other hand, consider that all cases of leucoplakia are of syphilitic origin. Some cases are undoubtedly due to smoking and chewing tobacco, owing to the impurities contained therein, such as ammonium carbonate, ammonium acetate and silver acetate, carbolic acid, and hydrocyanic acid.

Perrin considers that leucoplakia can be caused by excess of alcohol in people who are liable to injuries of the mouth, such as glass-blowers. Mercury is, again, a potent cause of leucoplakia. Other observers say that leucoplakia may be caused by gout, diseases of the intestinal tract, and diabetes.

Leucoplakia also occurs on the mucous membrane of the urethra, bladder, and ureters, as a result of chronic irritation, whether it be due to gonorrhœa or hypertrophy of the prostate. Leucoplakia can also affect the mucous membrane of the œsophagus, the vulva, and vagina. In the later situations it is not infrequently a forerunner of carcinoma. Histologically leucoplakia consists of a widening of the stratum Malpighii, with a marked hyperkeratosis, an increase in the size of the papillæ, and a small round-celled infiltration in the corium. In the atrophic stage the epidermis may be narrowed and thinned out, with the disappearance of the papillæ. It is only quite recently that leucoplakia of the glans penis and the inner layer of the prepuce has been recognised. In the cases described there was a marked degree of phimosis. Histologically there was found to be a marked absence of the elastic tissue in the sub-epithelial layer of the cutis.

In a case described by the author, owing to atrophy and ulceration occurring, the prepuce had become fixed to the glans penis. Balanitis is a frequent cause of this complaint, which is not uncommon in those where the phimosis is congenital.

Treatment is unavailing, and owing to the frequency with which carcinoma occurs surgical treatment is probably the best.

In all cases described where there has been leucoplakia of the skin, the involvement of the skin is due to direct continuation of the disease from a mucous membrane.

J. McD.

CONGENITAL SYPHILIS IN THE SECOND GENERATION. Bergrath. (*Archiv f. Derm. u. Syph.*, Bd. cv, Heft 1 and 2, p. 125.)

The patient, a child, aged 3 months, was brought up on account of a cold in the head (snuffles), which it had had for the last month, and a rash on both legs. All over the body was a typical syphilitic eruption; there was a general adenitis; the spleen was enlarged, but the liver only palpable. Wassermann's reaction was positive: fourteen days later the child died from intestinal catarrh. The mother was twenty-one years old when she married, had never had connection before marriage, nor cohabited with anyone except her husband. For the last five years she had complained of sleeplessness and headaches. Of four pregnancies two were born dead and two died soon after birth. The only clinical manifestation of syphilis she had was a gumma on the tongue. In spite of fourteen injections of mercury the Wassermann reaction remained positive. The grandmother of the child had been infected with syphilis before her marriage, and only two of her ten pregnancies lived to become adults. The father of the congenital syphilitic infant had never had connection with anyone except his wife, showed, on examination, no sign of syphilis, and his blood gave always, on repeated examinations, a negative Wassermann reaction. The father of the mother, that is, the grandfather of the patient, although he had no syphilitic manifestations, gave a positive Wassermann reaction. The brother of the mother of the congenital syphilitic child showed also no evidences of the disease, and gave a negative Wassermann reaction.

J. McD.

LICHEN PLANUS IN PERNICIOUS ANÆMIA. Spiethoff. (*Archiv f. Derm. u. Syph.*, Bd. cv, Heft 1 and 2, p. 169.)

The patient was a woman, aged 60 years, who for the last six months had been ill, and for the last eight weeks had complained of a pruritic eruption. She was anæmic, and the skin had a waxy appearance; there were hæmic cardiac murmurs, and more or less all over the body, and on the tongue were typical Lichen planus papules.

Blood examination.—Erythrocytes, 1,344,000; white corpuscles, 1500; hæmoglobin, 30 per cent.; colour index, over 1.

Differential count.—Polymorphonuclears, 26·8 per cent.; eosinophiles, 2·4 per cent.; myelocytes, ·5 per cent.; large mononuclears, ·6 per cent.; lymphocytes, 59·9 per cent.; gradation forms, ·4 per cent.

Among the red blood-corpuscles were normo- and megaloblasts, basophilic granules and polychromatic cells. In spite of arsenical treatment the patient died a few weeks later. A post-mortem examination revealed the usual pathological lesions met with in pernicious anæmia.

The histological examination of the skin-lesion fulfilled in every respect the picture one is accustomed to see in Lichen planus.

J. McD.

SYPHILITIC CHANCRES OF THE EAR. F. Krause. (*Monats. f. prakt. Derm.*, March 15th, 1911, p. 281.)

Krause has collected twenty-seven cases of such chancres, and when these cases are compared with the total number of extra-genital chancres recorded in the literature, *i. e.* 9058, the percentage works out to 0·185, or about 1 in 500.

The method of infection varies considerably. In six cases a kiss, in five cases a bite was the source of inoculation; some cases were caused by piercing the ears for the wearing of ear-rings, and one child was infected by a pair of forceps used at the confinement of the mother. A towel was the source of infection in one case, and a piece of sticking-plaster applied to the ear for a burn, moistened with syphilitic saliva, in another.

The induration of such chancres is usually very marked, and may be of a parchment-like character. Fournier has seen one such chancre become phagædenic, and in similar cases the subsequent destruction of tissue is great; otherwise the prognosis is good.

Of historical interest is the statement that Cardinal Wolsey suffered from syphilis, and that he inoculated, or attempted to inoculate, Henry VIII's ear with this disease. The same statement is made with regard to Cardinal Wolsey and Anne Boleyn.

J. L. B.

REPORT ON THE TREATMENT OF SYPHILIS BY INTRA-VENOUS INJECTIONS OF SALVARSAN. A. G. Rytina. (*New York Med. Journ.*, March 4th, p. 401.)

In his early experiences with salvarsan he tried both the subcutaneous and intra-muscular injections, and his results corresponded with the adverse reports alluded to in the literature. Since using the intra-venous injections, however, his results have been different, and in most instances brilliant.

In most of Rytina's early cases the intra-venous injections were given by the cannula method, which is exactly similar to the operation done for venous transfusion of normal salt solution. Recently he has been employing the original Schreiber method, reserving the cannula method for those rare cases where the Schreiber method is impracticable. The operation is absolutely painless and free from local reactive phenomena or complications, unless leakage in the cellular tissues occurs. This occurred only in one of his early cases.

The reaction phenomena following the intra-venous injection are more prompt and more intensive than in the other two methods.

From his studies and experience he feels justified in drawing the following conclusions: (1) Salvarsan possesses wonderful symptomatic efficiency. (2) Intra-venous injection is practically harmless, gives rises to neither pain nor complications, and is productive of better results than are obtained by either the subcutaneous or intra-muscular methods; furthermore, it produces results more quickly than can be attained by either mercury or potassium iodide, and very often cures lesions where heroic doses of mercury and potassium iodide have failed. (3) On account of its wonderful spirillocide action syphilis will be less prevalent, and there will be less liability to tertiary manifestations and the development of parasyphilis after the proper method of treatment has been fully ascertained. Whether this be the "chronic" injection treatment of Kromayer, the combination method of Iversen, injections every forty days as long as the Wassermann reaction persists, or the reinforcement of injections by courses of mercury and potassium iodide, for from six months to two years, only the future can tell.

J. L. B.

REVIEWS.

A Text-book of Urology.*

Max Nitze's premature death has deprived the world of a text-book by one of its greatest urologists, and his vast experience and wonderful skill are but dimly reflected in the scanty articles and monographs which we owe to his pen. Alfred Rothschild has, however, in this book tried to record some of his teaching, acquired during a period of three years spent with him, and has also given us the benefit of his own practical work and views on urological matters. The result is a volume which cannot but be of the greatest value to everyone interested in urinary diseases. To dermatologists also there is much that is interesting, both from a theoretical and practical point of view. Inasmuch as the prophylaxis of syphilis and gonorrhœa is much the same, the author's views on the prophylaxis of gonorrhœa will be read by many dermatologists with interest. A point which he brings out very clearly is that, although a single urethral infection with the gonococcus may be aborted or prevented by the employment of protargol or albargin solutions, the urethra is by these agents brought into such a condition of over-stimulation that it is predisposed even more than a normal urethra to subsequent infection as long as this pathological condition persists.

So much has been heard of the operation of prostatectomy that we turn with curiosity to the author's views as to the surgical treatment of hypertrophied prostate. According to statistics, a successful result of prostatectomy has been attained in 60 per cent. of operated cases. Forty per cent. of failures does not, of course, constitute an ideal operation, and it seems to be unquestionable that even after the most extensive "extirpation" the prostate may still undergo enlargement. Especially in cases of diffuse hypertrophy does this happen, for, however successfully the nodular enlargements may be removed in their own capsule, portions of the gland still remain and may give trouble later on. In this country the perinæal operation is less widely practised than the suprapubic, but Albarran considers it to be more radical. It is rather interesting to note that the author considers that syphilitic azoospermia can be cured by mercury. In other cases of sterility the operation of Fürbringer may be of value. By operation the presence of living spermatozoa is ascertained behind the obstruction in the seminal ducts, if any, and when the lesion is unilateral the healthy duct is separated from the diseased duct and sewed to an incision in the caput epididymis. In conclusion, we have pleasure in recommending the volume to all who are interested in urinary diseases. J. L. B.

Der Lupus, Seine Pathologie, Therapie, Prophylaxe.†

This little book contains a succinct and eminently practical account of Lupus vulgaris. The author begins by a useful classification of his cases into primary and secondary lupus. Primary lupus is relatively benign. It is characterised

* *Lehrbuch der Urologie und der Krankheiten der Männlichen Sexualorgane.* By Alfred Rothschild. Leipzig: Verleg von Dr. Werner Klinkhardt, 1911. Pp. 522.

† *Der Lupus, Seine Pathologie, Therapie, Prophylaxe.* By Prof. L. Philippson, of Palermo. Translated from the Italian Manuscript by Dr. F. Juliusberg. Berlin: Julius Springer. Price 2 marks.

by one or more discrete patches developing in healthy skin. It is almost certainly caused by local infection. Secondary lupus is (1) a sequel to tuberculosis of the glands, bones or joints, *i. e.* to surgical tuberculosis; and (2) secondary to tuberculosis of the nasal mucous membrane. It runs a more acute course than the primary variety, and tends to greater destruction. In a few instances the infection is brought by the blood-stream. Prof. Philippson divides his 135 cases into the following groups:

Primary lupus	42
Secondary to surgical tuberculosis	53
Secondary to nasal tuberculosis	26
Hæmatogenous	14
	135

The proportion of cases secondary to surgical tuberculosis appears unduly high, for Emlyn Jones found in the patients attending the London Hospital clinic that lupus was secondary to gland, bone or joint tuberculosis in only 11 per cent. (*Brit. Journ. Derm.*, September, 1907, p. 305). He, however, included only those cases in which definite lupus "nodules" were present.

We are pleased to see that Prof. Philippson lays stress upon the importance of recognising that a large number of cases of nasal lupus begin in the mucous membrane, and that effective treatment of the disease in the cavity will prevent the exterior of the organ becoming involved, and thereby avoid much disfigurement.

The destructive action of pyogenic organisms in lupus tissue is insisted upon, and the beneficial results of the use of simple antiseptic dressings, fomentations, etc., as a preliminary to the direct treatment of the tuberculous process will receive support from all practical dermatologists.

The author urges the importance of measures directed to the improvement of the general health, and looks upon the radical treatment of surgical tuberculosis as an important prophylactic. The various forms of local treatment are adequately discussed. All who have had experience with the Finsen treatment will agree that the most striking results are obtained in primary lupus of the skin. In the secondary forms phototherapy is best used as an adjuvant to other measures, but surprisingly good results are obtained in quiescent forms of this variety. The beneficial effects of the Röntgen rays in certain forms of lupus and in "scrofulous œdema" receive due recognition, and we are in entire agreement with the author in his statement that the influence of the rays upon the lupus infiltration is neither very safe nor very sure. Prof. Philippson is an advocate of Lang's method of excision, and rightly, in our opinion, restricts its use to early cases, where the underlying tissue is healthy, and to chronic decadent lesions in the adult.

There is only one point to which we feel disposed to take exception, and that is the author's suggestion that Lupus vulgaris should be called "Finsen's disease." The suggestion is a graceful tribute to the memory of the founder of scientific phototherapy, but there are already too many diseases and symptoms of disease called by the names of the individuals who have described them, and it would be an unfortunate precedent to attach the name of the inventor of a method of treatment, however successful, to a disease. The book has fourteen excellent illustrations from photographs. J. H. Sequeira.

SEVENTH INTERNATIONAL CONGRESS OF DERMATOLOGY.

ROME, 1911.

The Seventh International Congress of Dermatology will be held in Rome (at the Castel S. Angelo) from September the 25th to the 29th, 1911. *President:* Senatore Professor Tommaso de Amicis, of Naples. *Secretary-General:* Dr. Gaetano Ciarrocchi, 5, Piazza Grazioli, Rome.

The following subjects have been selected for discussion:

(1) The influence of the new etiological, diagnostic and experimental researches on the therapy of syphilis, and on the possibility of immunisation or of a radical or abortive treatment of the infection.

(2) The results of physico-therapy in diseases of the skin.

(3) Blastomycosis, sporotrichosis and their relation to analogous processes.

Members who have been invited to take part in the discussions or who intend to read papers should send a type-written abstract (of 5 or 6 lines) of their communication to the Secretary-General before the end of April.

A final programme will be published in May.

The fee for membership is £1.

The Secretary for Great Britain and Ireland, Dr. H. G. ADAMSON, 9, Weymouth Street, London, W., will be glad to give any further information to members or to those desirous of becoming members.

THE SEVENTEENTH INTERNATIONAL CONGRESS OF MEDICINE.

THE Seventeenth International Congress of Medicine will meet in London in the summer of 1913. The exact date is to be fixed by the International Permanent Committee, which will assemble for the first time in London, April 21st and 22nd next, under the presidentship of Dr. F. W. Pavy.

At the same meeting the list of Sections of the Congress will be constituted. Any wishes or propositions concerning the arrangement of this list may be sent to the Hon. General Secretary of the Permanent Committee, Prof. H. Burger, Vondelstraat 1, Amsterdam; or to the Bureau of the Committee, Hugo de Grootstraat 10, The Hague.

The Committee will be glad to receive, at an early date and at the same addresses, propositions and suggestions concerning the organisation of the Congress.

A CORRECTION.

On page 81 in the last number of the Journal the name *Serafero,* in Dr. Pernet's remarks, should read *Serajevo.*

PELLANTHUM.

Messrs. Handford and Dawson, of Harrogate, have sent us samples of "Pellanthum," a gelato-zinc basis introduced to overcome the difficulty and trouble of melting up each time when required for use gelatinum zinci (Unna's paste), yet still to produce an application which will dry quickly, forming a close, adherent film. Plain Pellanthum contains 20 per cent. zinc oxide, and we have found that it has the qualities claimed by the makers. It is easy of application, dries rapidly, and is easily washed off. It forms a convenient and cleanly basis for the use of ichthyol, resorcin, salicylic acid, liq. carbonis detergens, oil of cade and other medicaments.

LITERARY INTELLIGENCE.

Messrs. J. & A. Churchill have pleasure in announcing the publication of an important new *Text-Book of Diseases of the Skin,* by Dr. J. H. Sequeira, Lecturer and Physician to the Skin-Department at the London Hospital.

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